

## Appendix-2: Baseline questionnaire

### INTERVIEW INFORMATION

Respondent number.....

Hospital Name and Code \_\_\_\_\_

District \_\_\_\_\_

Taluka \_\_\_\_\_

City/Town/Village \_\_\_\_\_

Date of interview: DAY  MONTH  YEAR

Name and code of interviewer: \_\_\_\_\_

Interview Place: (HOSPITAL=1, HOME=2, OTHERS=3) \_\_\_\_\_  
(SPECIFY, IF OTHERS)

### INTERVIEWER VISITS

|                  | 1                    | 2                    | 3                    | FINAL VISIT   |
|------------------|----------------------|----------------------|----------------------|---|
| DATE             | <input type="text"/> | <input type="text"/> | <input type="text"/> | DAY..... <input type="text"/> <input type="text"/><br>MONTH..... <input type="text"/> <input type="text"/><br>YEAR..... <input type="text"/> <input type="text"/> |
| RESULT*          | <input type="text"/> | <input type="text"/> | <input type="text"/> | RESULT CODE* <input type="text"/>   |
| NEXT VISIT: DATE | <input type="text"/> | <input type="text"/> |                      | TOTAL NUMBER  |
| TIME             | <input type="text"/> | <input type="text"/> |                      | OF VISITS <input type="text"/>  |

**\*RESULT CODES:**

INTERVIEW COMPLETED=1

INTERVIEW PARTIALLY COMPLETED=2

RESPONDENT REFUSED TO TAKE PART=3

RESPONDENT SICK=4

## GENERAL QUESTIONNAIRE

### SOCIO-ECONOMICS STATUS

|               |  |
|---------------|--|
| 3.14 Religion | <input type="checkbox"/> Hinduism<br><input type="checkbox"/> Christianity<br><input type="checkbox"/> Islam<br><input type="checkbox"/> Others, <b>Specify:</b> _____ |
|---------------|--|

|  |  |
|--|--|
| 3.15 Is your husband a blood relative? | <input type="checkbox"/> YES <input type="checkbox"/> NO |
|--|--|

|   |  |
|---|--|
| 3.16 If <b>yes</b> to 3.15, please specify the relation |  |
|---|--|

|  |   |
|--|---|
| 3.17 Number of adults in the household | <div style="border: 1px solid black; width: 20px; height: 20px; display: inline-block;"></div> <div style="border: 1px solid black; width: 20px; height: 20px; display: inline-block;"></div> |
|--|---|

|  |   |
|--|---|
| 3.18 Number of children in the household | <div style="border: 1px solid black; width: 20px; height: 20px; display: inline-block;"></div> <div style="border: 1px solid black; width: 20px; height: 20px; display: inline-block;"></div> |
|--|---|

|                     |   |
|---------------------|---|
| 3.19 Type of family | <input type="checkbox"/> Nuclear<br><input type="checkbox"/> Extended<br><input type="checkbox"/> Joint |
|---------------------|---|

|   |  |  |
|---|--|--|
| 3.20 Education of the subject and her husband | <b>SUBJECT</b><br><input type="checkbox"/> Illiterate<br><input type="checkbox"/> Middle school (6-8th std)<br><input type="checkbox"/> High school (9-10 <sup>th</sup> std)<br><input type="checkbox"/> P.U.C/ Diploma<br><input type="checkbox"/> Graduate<br><input type="checkbox"/> Post graduate | <b>HUSBAND</b><br><input type="checkbox"/> Illiterate<br><input type="checkbox"/> Middle school (6-8th std)<br><input type="checkbox"/> High school (9-10 <sup>th</sup> std)<br><input type="checkbox"/> P.U.C/ Diploma<br><input type="checkbox"/> Graduate<br><input type="checkbox"/> Post graduate |
|---|--|--|

|  |  |
|--|--|
| 3.21 At the start of the pregnancy, was the subject working for pay? | <input type="checkbox"/> YES <input type="checkbox"/> NO |
|--|--|

|   |  |
|---|--|
| 3.22 Is the subject <b>currently</b> working for pay? | <input type="checkbox"/> YES <input type="checkbox"/> NO |
|---|--|

|  |  |  |
|--|--|--|
| 3.23 Occupation of the subject and her husband | <b>SUBJECT</b><br><input type="checkbox"/> Unemployed<br><input type="checkbox"/> Unskilled Worker<br><input type="checkbox"/> Skilled Worker<br><input type="checkbox"/> Petty business, shop owner<br><input type="checkbox"/> Secretarial staff, primary school teacher | <b>HUSBAND</b><br><input type="checkbox"/> Unemployed<br><input type="checkbox"/> Unskilled Worker<br><input type="checkbox"/> Skilled Worker<br><input type="checkbox"/> Petty business, shop owner<br><input type="checkbox"/> Secretarial staff, primary school teacher |
|--|--|--|

|  |  |  |
|--|--|--|
|  | <input type="checkbox"/> Semi-professional, high school teacher<br><input type="checkbox"/> Professional | <input type="checkbox"/> Semi-professional, high school teacher<br><input type="checkbox"/> Professional |
|--|--|--|

3.24 If yes to 3.22, monthly income of the **subject** RUPEES

|  |  |  |  |  |  |  |
|--|--|--|--|--|--|--|
|  |  |  |  |  |  |  |
|--|--|--|--|--|--|--|

3.25 Monthly income of the **subject's husband** RUPEES

|  |  |  |  |  |  |  |
|--|--|--|--|--|--|--|
|  |  |  |  |  |  |  |
|--|--|--|--|--|--|--|

3.26 Total number of **earning members** in the household

|  |  |
|--|--|
|  |  |
|--|--|

3.27 Total monthly income of the **household** RUPEES

|  |  |  |  |  |  |  |
|--|--|--|--|--|--|--|
|  |  |  |  |  |  |  |
|--|--|--|--|--|--|--|

### Standard of Living Index

3.28 Type of house (**CHOOSE ONLY 1**)

- ☐ Pucca  
☐ Semi-pucca  
☐ Kuccha

3.29 Does this household own this house or any other house?

☐ YES
 ☐ NO

3.30 How much agricultural land does this household **own**? (**CHOOSE ONLY 1**)

- ☐ ≥ 5 acres  
☐ 2.0 – 4.9 acres  
☐ < 2 acres  
☐ None

3.31 Out of this land, how much is **irrigated**?

- ☐ Some  
☐ None  
☐ Don't know

3.32 Does this household own any livestock?

☐ YES
 ☐ NO

3.33 Does this household have a separate kitchen?

☐ YES
 ☐ NO

|  |   |
|--|---|
| <p>3.34 What type of fuel does the household <b>mainly</b> use for cooking? <b>(CHOOSE ONLY 1)</b></p> | <input type="checkbox"/> Wood<br><input type="checkbox"/> Crop residues<br><input type="checkbox"/> Dung cakes<br><input type="checkbox"/> Coal/coke/lignite<br><input type="checkbox"/> Charcoal<br><input type="checkbox"/> Kerosene<br><input type="checkbox"/> Electricity<br><input type="checkbox"/> Liquid petroleum<br><input type="checkbox"/> Gas<br><input type="checkbox"/> Bio-gas |
| <p>3.35 What is the <b>main</b> source of lighting for the household? <b>(CHOOSE ONLY 1)</b></p>       | <input type="checkbox"/> Electricity<br><input type="checkbox"/> Kerosene<br><input type="checkbox"/> Gas<br><input type="checkbox"/> Oil   |

|   |   |
|---|---|
| <p>3.36 What is the <b>main</b> source of drinking water for members of the household? <b>(CHOOSE ONLY 1)</b></p> | <p><b>PIPED WATER</b></p> <input type="checkbox"/> Piped into Residence/Yard/Plot<br><input type="checkbox"/> Public Tap<br><p><b>GROUND WATER</b></p> <input type="checkbox"/> Hand pump in residence/Yard/Plot<br><input type="checkbox"/> Public Hand pump<br><p><b>WELL WATER (WELL IN RESIDENCE/YARD/PLOT)</b></p> <input type="checkbox"/> Covered well<br><input type="checkbox"/> Open well<br><input type="checkbox"/> Public Well<br><p><b>SURFACE WATER</b></p> <input type="checkbox"/> Spring<br><input type="checkbox"/> River/Stream<br><input type="checkbox"/> Pond/Lake<br><input type="checkbox"/> Dam<br><input type="checkbox"/> Rain water<br><input type="checkbox"/> Tanker truck |
| <p>3.37 What kind of <b>toilet</b> facility does the household have? <b>(CHOOSE ONLY 1)</b></p>                   | <p><b>FLUSH TOILET</b></p> <input type="checkbox"/> Own Flush Toilet<br><input type="checkbox"/> Shared Flush Toilet<br><input type="checkbox"/> Public Flush Toilet  |

|  |  |
|--|--|
|  | <b>PIT TOILET/ LATRINE</b><br><input type="checkbox"/> Own pit toilet/latrine<br><input type="checkbox"/> Shared toilet/latrine<br><input type="checkbox"/> Public toilet/latrine<br><input type="checkbox"/> NO FACILITY/ BUSH/ FIELD |
|--|--|

|  |                                |                              |                             |
|--|--------------------------------|------------------------------|-----------------------------|
| 3.38 Does this household own any of the following? | A Mattress                     | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
|  | A Pressure Cooker              | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
|  | A Chair                        | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
|  | A Cot or Bed                   | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
|  | A Table                        | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
|  | A clock or watch               | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
|  | An electric fan                | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
|  | A bicycle                      | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
|  | A radio or transistor          | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
|  | A sewing machine               | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
|  | A telephone                    | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
|  | A mobile phone                 | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
|  | A refrigerator                 | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
|  | A color television             | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
|  | A moped, scooter or motorcycle | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
|  | A auto                         | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
|  | A car                          | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
|  | A tempo                        | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
|  | A water pump                   | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
|  | A bullock cart                 | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| A thresher   | <input type="checkbox"/> YES   | <input type="checkbox"/> NO  |                             |
| A tractor  | <input type="checkbox"/> YES   | <input type="checkbox"/> NO  |                             |

## MEDICAL AND OBSTETRICS HISTORY

### 4.4 Obstetrics history

|   |  |
|---|--|
| 4.4a Gravida  | <input type="checkbox"/> 0<br><input type="checkbox"/> 1<br><input type="checkbox"/> 2<br><input type="checkbox"/> 3<br><input type="checkbox"/> 4<br><input type="checkbox"/> 5 |
| 4.4b Parity<br>(Number of times a woman has given birth to a fetus with a gestational age of 28 weeks or more, regardless of whether the child was born alive or was stillborn) | <input type="checkbox"/> 0<br><input type="checkbox"/> 1<br><input type="checkbox"/> 2<br><input type="checkbox"/> 3<br><input type="checkbox"/> 4                               |
| 4.4c Abortion<br>(Number of times a woman has given birth to a fetus with a gestational age of 28 weeks or less)  | <input type="checkbox"/> 0<br><input type="checkbox"/> 1<br><input type="checkbox"/> 2<br><input type="checkbox"/> 3<br><input type="checkbox"/> 4<br><input type="checkbox"/> 5 |
| 4.4d Living Children<br>(Number of times a woman has given birth to a live fetus)   | <input type="checkbox"/> 0<br><input type="checkbox"/> 1<br><input type="checkbox"/> 2<br><input type="checkbox"/> 3<br><input type="checkbox"/> 4                               |

## MONTHLY MEDICAL HISTORY

7.16 Since pregnancy/ past one month, have you experienced the following symptoms or diseases?

Read the following symptoms or diseases and mark out all symptoms/diseases that the SUBJECT has experienced.

| Symptoms / Disease  | YES                      | NO                       | DK                       |
|---|--------------------------|--------------------------|--------------------------|
| a) Diarrhea (>3 loose, watery stools /day)                  | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| b) Dysentery (Diarrhea containing mucus and blood in feces) | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| c) Nausea   | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| d) Vomiting   | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| e) Fever  | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| f) Productive Cough / cold                                  | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

|   |                          |                          |                          |
|---|--------------------------|--------------------------|--------------------------|
| g) Sore throat  | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| h) Wheezing (high-pitched whistling sound during breathing) | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| i) Giddiness  | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| j) Tiredness  | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| k) Abdominal pain   | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| l) Ear pain   | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| m) Heart burn   | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| n) Constipation   | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| o) Vaginal bleeding   | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| p) Pain during urination                                    | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| q) Convulsions  | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| r) Mouth ulcers   | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| s) Headache   | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| t) Backache   | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| u) Skin related problems <b>specify</b><br>_____            | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| w) Others, <b>Specify</b> _____                             | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

## BLOOD PRESSURE OF THE MOTHER

7.19 Blood pressure

Systolic Clinical reading

  

mm/Hg

7.20 Blood pressure

Diastolic Clinical reading

  

mm/Hg

7.21 Blood pressure

Systolic Automated reading

  

mm/Hg

7.22 Blood pressure

Diastolic Automated reading

  

mm/Hg

## MOTHER ANTHROPOMETRY

| Measurements      | Reading 1   | Reading 2   | Reading 3   |
|-------------------|---|---|---|
| 8.7ba Weight (kg) | <input type="text"/> <input type="text"/> <input type="text"/> . <input type="text"/> | <input type="text"/> <input type="text"/> <input type="text"/> . <input type="text"/> | <input type="text"/> <input type="text"/> <input type="text"/> . <input type="text"/> |
| 8.7bb Height (cm) | <input type="text"/> <input type="text"/> <input type="text"/> . <input type="text"/> | <input type="text"/> <input type="text"/> <input type="text"/> . <input type="text"/> | <input type="text"/> <input type="text"/> <input type="text"/> . <input type="text"/> |

## BIOCHEMICAL INVESTIGATION

|                          |   |
|--------------------------|---|
| Date of blood test _____ |   |
| a. Blood group           | <input type="checkbox"/> A Positive <input type="checkbox"/> A Negative<br><input type="checkbox"/> B Positive <input type="checkbox"/> B Negative<br><input type="checkbox"/> AB Positive <input type="checkbox"/> AB Negative<br><input type="checkbox"/> O Negative <input type="checkbox"/> O Positive <input type="checkbox"/> DK/NA<br><input type="checkbox"/> RH Negative <input type="checkbox"/> RH Positive <input type="checkbox"/> DK/NA |
| b. Hemoglobin (g/dl)     | <input type="text"/> <input type="text"/> <input type="text"/> . <input type="text"/> DK/NA <input type="text"/>  |